

**RANKIN & SULTAN**

ATTORNEYS AT LAW

CHARLES W. RANKIN  
JAMES L. SULTAN  
CATHERINE J. HINTON

MICHELLE MENKEN  
AMY S. ALBERT

ONE COMMERCIAL WHARF NORTH  
BOSTON, MASSACHUSETTS 02110  
(617) 720-0011

FAX (617) 742-0701  
EMAIL OFFICE@RANKIN-SULTAN.COM

July 29, 2004

CAB Health and Recovery Services  
Medical Records Department  
11 Middleton Road  
Danvers, MA 01923

Re: **Joseph M. Allen – DOB 5/30/78**

Dear CAB:

I am writing to request that you send me a copy of your records pertaining to your treatment of my client, Joseph M. Allen earlier this year. These records are important to my representation of Mr. Allen in a pending criminal case. I am enclosing a release signed by Mr. Allen authorizing you to release his records to me. If you require any additional information, please contact me directly. If there is a charge for copying these documents, please let me know and I will forward payment.

Thank you for your anticipated assistance.

Sincerely yours,



James L. Sultan

JLS:pcb

Enclosure

*Copies  
forwarded  
to acctg.  
8/1/04*



JUL-23-04 02:44PM FROM-CAB HEALTH &amp; RECOVERY

978-774-4814

T-116 P 001/001 F-472

011-111



CAB Health &amp; Recovery Services

# **AUTHORIZATION (CONSENT) TO OBTAIN OR RELEASE INFORMATION AND RECORDS**

Client Name: JOSEPH M ALLEN DOB: 5-30-78 DRS#: (CAB use only):

**OBTAIN:** I, JOSEPH M ALLEN (Client or Parent/Guardian, if client is a minor) authorize CAB Health and Recovery Services, Inc., by fax or mail, to **obtain** information including medical and/or substance abuse and/or mental health records from:

(Name and telephone number of agency/school/physician)

(Complete mailing address of agency/school/physician)

**RELEASE:** I, JOSEPH M ALLEN (Client or Parent/Guardian, if client is a minor) authorize CAB Health & Recovery Services, Inc., via U.S. mail, to **release** information including medical and/or substance abuse and/or mental health records to:

ATTORNEY JAMES SULTAN (617) 720-0011  
(Name and telephone number of agency/school/physician) FAX (617) 742-0701

ONE COMMERCIAL WHARF NORTH  
(Complete mailing address of agency/school/physician)

Boston MASS 02110

Please indicate the **SPECIFIC** information to be disclosed: (Please complete each category):

<input checked="" type="checkbox"/> <b>N</b> Dates of Services	<input checked="" type="checkbox"/> <b>N</b> Progress Notes
<input checked="" type="checkbox"/> <b>N</b> Intake Assessment Summary (Clinical Interview)	<input checked="" type="checkbox"/> <b>N</b> Discharge Summary
<input checked="" type="checkbox"/> <b>N</b> Treatment Plans	<input checked="" type="checkbox"/> <b>N</b> Psychiatric Summaries/Medications
<input checked="" type="checkbox"/> <b>N</b> Diagnoses	Other <u>EVERY THING</u>

The purpose of this release of information is:

☐ Assist in Treatment Planning ☐ Coordination of Treatment ☐ Evaluation  
☐ Billing for Treatment Services Rendered  
☒ Other (specify): Legal

## **PROTECTED INFORMATION**

Your signature below does not pertain to the categories listed below. Information in these protected categories will **not** be recorded or released from your record without your initials in the boxes below in addition to your signature.

## **INITIAL ONLY THE CATEGORIES OR INFORMATION YOU WISH CAB HEALTH & RECOVERY SERVICES, INC. TO RELEASE:**

<input checked="" type="checkbox"/> Hepatitis B Testing/Treatment	<input checked="" type="checkbox"/> HIV/AIDS <input checked="" type="checkbox"/> HIV Testing	<input checked="" type="checkbox"/> Sexually Transmitted Diseases	<input checked="" type="checkbox"/> Hepatitis C Testing/Treatment
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I understand that I have the right to inspect and copy the information to be disclosed. I understand that my records are protected under the federal regulations governing Confidentiality in Alcohol and Drug Abuse Patients, 42 CFR Part 2 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent automatically expires within 30 days after treatment, termination, or upon receipt of payment for treatment services rendered, whichever is longer, unless otherwise specified below:

(Specification of the date, event, or condition upon which this consent expires, not to exceed one year.)

Client Signature:

Joseph M Allen  
Witness: JR

Date:

July 27, 2004

Parent/Guardian:



**Response Information for**

<b>RID:</b>	029582491	<b>SSN:</b>		<b>Sequence:</b>	
<b>First Name:</b>		<b>Date of Service:</b>	3/24/2004		
<b>Last Name:</b>		<b>Local Office:</b>			
<b>Status:</b>	Patient not found				



**Admissions Form**

Form Completed by: \_\_\_\_\_

Scheduled Admission Date: <u>3/25/04</u>		BSA # <u>BSA # 3398346</u>		MRN#: <u>4595</u> ✓
Client Name (Last, First, Middle) <u>Allen, Joseph</u>		<u>Allen, Joseph</u>		
DOB: <u>5/30/78</u>	Sex: <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		SSN: <u>629-582491</u>	
Home Phone: <u>978 479 6192</u>	Address: <u>8 Reservoir Rd. Gloucester, Mass. 01930</u> <u>8 Reservoir Rd, Gloucester 01930</u>			
AXIS I  <u>304.00</u>		Type of Service <input checked="" type="checkbox"/> Detoxification <input type="checkbox"/> Dual Diagnosis <input type="checkbox"/> Federal <input type="checkbox"/> Section 35 <input type="checkbox"/> Pregnant <input type="checkbox"/> Methadone		
AXIS I: <b>DIAGNOSIS</b>				
<b>PAY SOURCE INFORMATION</b> <input type="checkbox"/> MASS HEALTH <input type="checkbox"/> HMO <input type="checkbox"/> DMA <input checked="" type="checkbox"/> POS VERIFICATION <input type="checkbox"/> Medicaid <input type="checkbox"/> Fallon <input type="checkbox"/> BMC-HealthNet <input type="checkbox"/> Federal <input type="checkbox"/> Eligible <input checked="" type="checkbox"/> MBHP <u>Bosco</u> <input type="checkbox"/> HMO Blue <input type="checkbox"/> NHP <input type="checkbox"/> Medicare <input type="checkbox"/> Not Eligible <u>ERROR</u> <input type="checkbox"/> Network <input type="checkbox"/> Other <input type="checkbox"/> Self Pay <input checked="" type="checkbox"/> Not Found <input type="checkbox"/> Ubh				
Cardholder Name:		Policy #:		SSN:
Employer:		Policy #:		Group #:
Insurance Co.:		Policy #:		Group #:
Address:				Phone:
Verification Date:		Verified by:		# of Days Approved:
Authorization #:				
Family Plan:	Deductible:	Individual:	Co-Pay:	

MDC 3/25-3/27 2 units App



### Response Information for

**RID:** 029582491  
**First Name:**  
**Last Name:**  
**Status:** Patient not found  
**SSN:**  
**Date of Service:** 3/24/2004  
**Local Office:**

**Sequence:**



Joseph Allen

119B



**CAB**  
HEALTH & RECOVERY  
SERVICES, INC.

# Admission Checklist

? Insurance

Treatment makes a difference Recovery makes a life

- ☒ MIS stickers on all MIS forms (6 pages)
- ☒ MIS stickers on yellow billing sheet and physicians orders (protocol) sheet
- ☐ MIS number written in on pages 6, 7, 10, 14 and Kardex

\* ☒ MIS form "Part 1" completed on Admission

\* ☒ Yellow billing sheet completely filled out on admission

\* ☒ Copy of Revs PC computer printout with billing info

\* ☐ If private insurance, photocopy of clients insurance card

\* ☐ If no insurance have client sign DMA form.

*Temp Card*  
☒ Client has signed all pertinent paperwork

☐ RN has completed and signed nursing medical assessment.

Nurse Signature:

*nmolbrax*

Date:

*3/25/04*

- To be put in Billing Department mailbox.



# Temporary MassHealth Card

35 CONGRESS STREET - SALEM, MA

AGE/CIT/AO	CAT	For MassHealth eligibility questions, call 1-800-841-2900 (TTY: 1-800-497-4648 for the deaf and hard of hearing) (637)
262	04	

Eligible  
from: 03/24/2004

Eligible  
through 04/23/2004

Messages:

CAT 04: EAEDC  
LIMITED SERVICES ONLY

Name/PIID of Eligible Person	Age	Sex	Ras	TPPL
JOSEPH ALLEN 029-58-2491-3	25	M	O	
(1) ONE PERSON ELIGIBLE				

See back of card for more information.

T 2043088

Issued to:

JOSEPH ALLEN  
35 CONGRESS STREET  
SALEM, MA 01970

Please sign right away.

*Joseph Allen*



SITE CODE     □    □    □    □    □

[illegible][illegible]

**DRUNKEN DRIVER CLIENTS**

(Admission to DAE and 14-day D<sub>U</sub>IL only)

34. Date of arrest (mmddy)

35. Referring Court

(Court codes on back of yellow page)

## MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

## MIS INTERVIEW - COURT AND RESPONSE CODES

## SUBSTANCE ABUSE SERVICES

COURT	CODES	COURT	CODES	RESPONSE CODES FOR HANDICAPS/DISABILITIES AND TREATMENT HISTORY
Adams	004	Leominster	153	<b>26 Vision Impairment</b>
Amesbury	007	Lowell	160	0 = None - Normal vision requiring no correction
Attleboro	016	Lynn	163	1 = Slight - Vision is or can be adequately corrected with glasses/lenses
Ayer	019	Malden	165	2 = Moderate - "Legally blind" but having some minimal vision
Barnstable	020	Marlboro	170	3 = Severe - No usable vision
BOSTON	035	Milford	185	<b>27 Hearing Impairment</b>
Brighton	352	Nantucket	197	0 = None - Normal hearing requiring no correction
Charlestown	353	Natick	198	1 = Slight - Hearing is or can be adequately compensated with amplification, (e.g. hearing aid)
Dorchester	354	New Bedford	201	2 = Moderate - Hard of hearing, even with amplification
East Boston	355	Newburyport	206	3 = Severe - Profound deafness
Roxbury	360	Newton	207	<b>28 Self Care/Activities of Daily Living (ADL)</b>
South Boston	361	North Adams	209	0 = None - No Problem with accomplishing ADL skills such as bathing, dressing and other self care
West Roxbury	362	Northampton	214	1 = Slight - Uses an adaptive device/s and/or takes additional time to accomplish ADL but does not require a personal attendant
Brockton	044	Orange	223	2 = Moderate - Needs personal attendant up to 20 hours a week for ADL
Brookline	046	Orleans	224	3 = Severe - Requires personal attendant for over 20 hours a week for ADL
Cambridge	049	Palmer	227	<b>29 Mental Retardation</b>
Chelsea	057	Peabody	229	0 = None
Chicopee	061	Pittsfield	236	1 = Slight
Clinton	064	Plymouth	239	2 = Moderate
Concord	067	Quincy	243	3 = Severe
Dedham	073	Salem	258	<b>30 Prior Mental Health Treatment *</b>
Dudley	080	Somerville	274	0 = has no prior mental health treatment history
Edgartown	089	Spencer	280	1 = no treatment history but obvious problem
Fall River	095	Springfield	281	2 = has received counseling for mental health problem
Fitchburg	097	Stoughton	285	3 = has one hospitalization for mental health problem
Framingham	100	Taunton	293	4 = has more than one hospitalization for mental health problem
Gardner	103	Uxbridge	304	
Gloucester	107	Waltham	308	
Great Barrington	113	Ware	309	
Greenfield	114	Wareham	310	
Haverhill	128	Westborough	328	
Hingham	131	Westfield	329	
Holyoke	137	Winchendon	343	
Ipswich	144	Woburn	347	
Lawrence	149	Worcester	348	
Lee	150	Wrentham	350	

\* = If the client has received more than one type of treatment listed above, code the highest number that applies

**DRUNKEN DRIVER CLIENTS**

(Admission to DAE and 14-day DUI. only)

34. Date of arrest (mmddyy)

35. Referring Court

(Court codes on back of yellow page)

**PATTERN OF SUBSTANCE USE**

Complete 36 for all substances. If 36 = 0 leave 37-39 blank.

*Use codes on back of pink copy for 37-39*

	36.	37.	38.	39.
	Age of first use	Last use (code)	Freq. of last reg. use (code)	Usual route of admin. (code)
A. Alcohol				
B. Cocaine				
C. Crack				
D. Marijuana/hashish				
E. Heroin				
F. Non Rx Methadone				
G. Oth. Opiates/Synthetics	23	5	5	3
H. PCP				
I. Oth. Hallucinogens				
J. Methamphetamine				
K. Oth. Amphetamines				
L. Oth. Stimulants				
M. Benzodiazepines				
N. Oth. Tranquilizers				
O. Barbiturates				
P. Oth. Sedatives/Hypnotics				
Q. Inhalants				
R. Over-the-counter				
S. Other				

**40. Ranking of Substance Abuse Problems**

*(Use alphabetical letter from substance list above)*

Primary Substance	<input checked="" type="checkbox"/>	Secondary Substance	<input type="checkbox"/>	Tertiary Substance	<input type="checkbox"/>
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41. Last needle use (Use code for 37/never = 0)

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## MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

## MIS INTERVIEW - TOWN CODES

## SUBSTANCE ABUSE SERVICES

TOWN	CODES	TOWN	CODES	TOWN	CODES	TOWN	CODES	TOWN	CODES	TOWN	CODES
Abington	001	Chicopee	061	Hathorne (See Danvers)		Natick	198	Skelbourne	268	Williamsburg	340
Acron	002	Chilmark	062	Heath	130	Needham	199	Sherborn	269	Williamstown	341
Acushnet	003	Clarksburg	063	Hingham	131	New Ashford	200	Shirley	270	Williamston	342
Adams	004	Clinton	064	Hinsdale	132	New Bedford	201	Shrewsbury	271	Winchendon	343
Agawan	005	Cohasset	065	Holbrook	133	New Braintree	202	Shutesbury	272	Winchester	344
Alford	006	Colrain	066	Holden	134	New Marlboro	203	Somerset	273	Windor	345
Akersbury	007	Concord	067	Holland	135	New Salem	204	Somerville	274	Winthrop	346
Amherst	008	Conway	068	Holliston	136	Newbury	205	South Hadley	275	Woburn	347
Andover	009	Cummington	069	Holyoke	137	Newburyport	206	Southampton	276	Worcester	348
Arlington	010			Hopkdale	138	Newton	207	Southwick	277	Worthington	349
Ashburnham	011	Dutton	070	Hopkinton	139	Norfolk	208	Southbridge	278	Wrentham	350
Ashby	012	Danvers	071	Hubbardston	140	North Adams	209	Southwick	279		
Ashfield	013	Hathorne	072	Hudson	141	North Andover	210	Spencer	280	Yarmouth	351
Ashland	014	Dedham	073	Hyannis	142	North Attleboro	211	Springfield	281		
Attleboro	015	Deerfield	074	Hyannis (See Barnstable)	143	North Brookfield	212	Sterling	282		
Auburn	016	Dennis	075			North Reading	213	Stockbridge	283		
Avon	017	Dighton	076			Northampton	214	Stoughton	284		
Ayer	018	Douglas	077	Uxbridge	144	Northboro	215	Stoughton	285		
	019	Dover	078	Kingston	145	Northfield	216	Stow	286		
Barnstable/	020	Draught	079			Northford	217	Sturbridge	287		
Hyannis	021	Dudley	080			Norton	218	Sturbridge	288		
Barre	022	Dunstable	081	Lakeville	146	Norwell	219	Sunderland	289		
Becket	023	Duxbury	082	Lancaster	147	Norwood	220	Sutton	290		
Bedford	024			Lawrence	148			Swampscott	291		
Bellevue	025	East Bridgewater	083	Lee	149	Oak Bluffs	221	Swansea	292		
Bellingham	026	East Brookfield	084	Leicester	150	Oakham	222				
Belmont	027	East Longmeadow	085	Leicester	151	Orange	223	Taunton	293		
Berkley	028	Eastham	086	Lenox	152	Orange	224	Templeton	294		
Berlin	029	Easthampton	087	Leicester	153	Orleans	225	Tewksbury	295		
Beverly	030	Edgartown	088	Lexington	154	Oxford	226	Tisbury	296		
Billerica	031	Egmont	089	Lexington	155			Tolland	297		
Blackstone	032	Erving	090	Leyden	156	Pahner	227	Toronto	298		
Blandford	033	Essex	091	Lincroft	157	Paxton	228	Townsend	299		
Bolton	034	Everett	092	Littleton	158	Peabody	229	Truro	300		
BOSTON	035			Longmeadow	159	Pedham	230	Tyringboro	301		
Allston-Brighton	352	Fairhaven	094	Lowell	160	Pembroke	231	Tyringham	302		
Charlestown	353	Fall River	095	Ludlow	161	Pepperell	232	Upton	303		
Dorchester	354	Falmouth	096	Lynn	162	Peterborough	233	Uxbridge	304		
East Boston	355	Fitchburg	097	Lynnfield	163	Petersham	234				
Hyde Park	356	Florida	098	Malden	164	Phillipston	235				
Jamaica Plain	357	Foxboro	099	Malden	165	Pittsfield	236	Wakefield	305		
Mattapan	358	Framingham	100	Manchester	166	Plainfield	237	Wales	306		
Roslindale	359	Franklin	101	Mansfield	167	Plainville	238	Walpole	307		
Roxbury	360	Freetown	102	Marblehead	168	Plymouth	239	Walworth	308		
South Boston	361			Marion	169	Plymouth	240	Ware	309		
West Roxbury	362	Gardner	103	Marlboro	170	Princeton	241	Ware	310		
Bourne	036	Gav Head	104	Marshfield	171	Provincetown	242	Warren	311		
Boxford	037	Georgetown	105	Mattapoisett	172	Quincy	243	Warwick	312		
Boxborough	038	Gill	106	Mattapoisett	173			Watertown	313		
Boylston	039	Gloucester	107	Mattapoisett	174	Randolph	244	Watertown	314		
Brannock	040	Goshen	108	Medford	175	Ravenna	245	Webster	315		
Brewster	041	Gosnold	109	Medway	176	Reading	246	Wellesley	316		
Bridgewater	042	Grafton	110	Melrose	177	Rehoboth	247	Wellesley	317		
Brimfield	043	Granville	111	Mendon	178	Revere	248	Wendell	318		
Brookline	044	Great Barrington	112	Merrimack	179	Richmond	249	West Boylston	319		
Brookfield	045	Greenfield	113	Methuen	180	Rochester	250	West Bridgewater	320		
Brookline	046	Groton	114	Middleboro	181	Rockland	251	West Brookfield	321		
Buckland	047	Groton	115	Middlefield	182	Rockport	252	West Newbury	322		
Burlington	048	Groveland	116	Middleton	183	Roxbury	253	West Newbury	323		
		Hadley	117	Milford	184	Rowley	254	West Springfield	324		
		Haltax	118	Millbury	185	Royalston	255	West Stockbridge	325		
		Hampton	119	Millis	186	Russell	256	West Tisbury	326		
		Hampton	120	Millville	187	Rutland	257	Westboro	327		
		Hancock	121	Milton	188	Salem	258	Westfield	328		
		Hanover	122	Monroe	189	Salem	259	Westhampton	329		
		Hanson	123	Monroe	190	Sandwich	260	Westminister	330		
		Harvard	124	Montague	191	Sandwich	261	Weston	331		
		Harwich	125	Monterey	192	Saugus	262	Westport	332		
		Harwich	126	Monterey	193	Savoy	263	Westwood	333		
		Haverhill	127	Mount Washington	194	Scituate	264	Weymouth	334		
		Haverhill	128	Nahant	195	Scituate	265	Whitely	335		
		Hawley	129	Nahant	196	Scituate	266	Whitman	336		
				Nantucket	197	Scituate	267	Whitman	337		
						Scituate	268	Whitman	338		
						Scituate	269	Whitman	339		

## OUT OF STATE RESIDENCE

Connecticut 401  
Maine 402  
New Hampshire 403  
New York 404  
Rhode Island 405  
Vermont 406  
Other States 407  
None of the above 408

## CORRECTIONAL INSTITUTION RESIDENCE

County  
Barnstable County 500  
Berkshire/Putnam 505  
Bristol/New Bedford/No. Dartmouth 510  
New Bedford/EMCAC 511  
Lawrence/Corr. Alt. Cr. 515  
Dukes/Edgartown Jail 520  
Essex/Lawrence 525  
Franklin/Greenfield 540  
Hampshire/No. Hampton 545  
MSEX/Billerica 550  
Cambridge Jail 555  
Norfolk/Dedham 560  
Plymouth County 565  
Suffolk/Nashua Street Jail 570  
Deer Island 575  
Worcester County 580

State  
Bay State Corr. Cr./Norfolk 600  
Boston State Pre-Release/Dorch. 605  
Linnell Shattuck Hosp. Unit 610  
MCI/Bridgewater 615  
MCI/Concord 620  
MCI/Framingham 625  
MCI/Lancaster 630  
MCI/Plymouth 635  
MCI/Norfolk 640  
MCI/Shirley 645  
MCI/Cedar Jct. 650  
MCI/Warwick 655  
Medfield Prison Project 660  
Norfolk Pre-Release 665  
No. Cent. Corr. Cr./Gardner 670  
N.E. Corr. Cr. 675  
Park Drive Pre-Release - Boston 680  
So. Middlesex Pre-Release - Framming 685  
S.E. Corr. Cr./Bridge 690  
Treatment Cr./Bridge 695  
Superior Court 700  
Longwood 705

B5A #	339834
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1. Admission number
2. Agency code
3. Program's client ID
4. Exit Date (mmddyy)
5. Reason for discharge\*
6. Discharge plan (Y = yes, N = no)
7. Referred self help group (Y = yes, N = no)
8. Where was client referred\*
9. Employment status at discharge\*
10. Number of days worked past month

COLLATERAL CLIENTS STOP HERE

**OTHER SOCIAL/HEALTH SERVICES**  
(Provided to client during treatment)

not provided 0 = provided	1 = your agency provided by different agency 2 =	Code
11. Legal aid/services		<input type="checkbox"/>
12. Housing		<input type="checkbox"/>
13. GED		<input type="checkbox"/>
14. Vocational training		<input type="checkbox"/>
15. Family planning		<input type="checkbox"/>
16. Child Care		<input type="checkbox"/>
17. Literacy services		<input type="checkbox"/>
18. English as second language		<input type="checkbox"/>
19. Job placement/referral		<input type="checkbox"/>
20. Prenatal medical care		<input type="checkbox"/>
21. Postpartum medical care		<input type="checkbox"/>
22. Urine drug screening		<input type="checkbox"/>
23. Treatment for medical problems		<input type="checkbox"/>
24. Treatment for emotional problems		<input type="checkbox"/>

	not provided 0 = provided	provided by your agency 1 = provided	provided by different agency 2 = provided
25. Medication for withdrawal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Medication for medical problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Medication for emotional problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. TB testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. TB treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. STD testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. STD treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DETOX CLIENTS STOP HERE

**EVALUATION OF CLIENTS GOAL ACHIEVEMENT**  
(Mark X in appropriate boxes)

	Not applicable	Achieved	Partial achievement	Not achieved
32. Overall program goals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Alcohol use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Educational/Vocational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. Social functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. Emotional functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. Family situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. Illegal behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

40. Currently receiving services from state agencies? (**Mark X for all that apply**)

None <input type="checkbox"/>	DSS <input type="checkbox"/>	DYS <input type="checkbox"/>	DOC <input type="checkbox"/>	MPB <input type="checkbox"/>	OCP <input type="checkbox"/>	DMH <input type="checkbox"/>	DMR <input type="checkbox"/>
DPH <input type="checkbox"/>	DTA <input type="checkbox"/>	OCES <input type="checkbox"/>	MRC <input type="checkbox"/>	MCB <input type="checkbox"/>	MCDHH <input type="checkbox"/>	OTH <input type="checkbox"/>	

40. Currently receiving services from state agencies?  
(Mark X for all that apply)

DMR	<input type="checkbox"/>	DMH	<input type="checkbox"/>	OTH	<input type="checkbox"/>
OCF	<input type="checkbox"/>	MCDFH	<input type="checkbox"/>		
MPB	<input type="checkbox"/>	MCB	<input type="checkbox"/>		
DOC	<input type="checkbox"/>	MRC	<input type="checkbox"/>		
DYS	<input type="checkbox"/>	OCCS	<input type="checkbox"/>		
DSS	<input type="checkbox"/>	DTA	<input type="checkbox"/>		
None	<input type="checkbox"/>	DPH	<input type="checkbox"/>		

24. Treatment for emotional problems

OUTPATIENT CLIENTS (Includes methadone and DAE clients)	
41. Drinking behavior at discharge 0 = no alcohol use    3 = increased use 1 = decreased use    9 = unknown 2 = no change	<input type="checkbox"/>
42. Drug use other than alcohol at discharge 0 = no drug use    3 = increased use 1 = decreased use    9 = unknown 2 = no change	<input type="checkbox"/>
43. Alcohol use freq. since admission*	<input type="checkbox"/>
44. Drug (Other than alcohol) used most since admission* (none = X)	<input type="checkbox"/>
45. Drug (Other than alcohol) use frequency since admission* (nc use = 0) (If more than one - drug used most)	<input type="checkbox"/>

**DRUNKEN DRIVER CLIENTS**  
(Discharge from DAE and 14-day DUI only)

46. Date first group (mmddyy)

47. BAC this arrest

Enter two digits only. No decimal point  
88 = does not know, 99 = refused test

48. Lifetime arrests for DUI

49. DUI convictions past 6 years. Include current conviction. Do not include subsequent convictions

50. Interviewer Initials	<input type="text"/>	<input type="text"/>	<input type="text"/>
51. Special Studies	<input type="text"/>	<input type="text"/>	<input type="text"/>

**\*\* See code numbers on back of pink copy.**



MIS INTERVIEW - PART 2 (DISCHARGE)

BSA # 3398346	
1. Admission number	
2. Agency code	
3. Program's client ID	
4. Exit Date (mumddy)	
5. Reason for discharge*	
6. Discharge plan (Y = yes, N = no)	
7. Referred self help group (Y = yes, N = no)	
8. Where was client referred*	
9. Employment status at discharge*	
10. Number of days worked past month	

**COLLATERAL CLIENTS STOP HERE**

**OTHER SOCIAL/HEALTH SERVICES**  
*(Provided to client during treatment)*

not provided 0 =	provided 1 = your agency	provided by different agency 2 =	Code
	11. Legal aid/services	<input type="checkbox"/>	
	12. Housing	<input type="checkbox"/>	
	13. GED	<input type="checkbox"/>	
	14. Vocational training	<input type="checkbox"/>	
	15. Family planning	<input type="checkbox"/>	
	16. Child Care	<input type="checkbox"/>	
	17. Literacy services	<input type="checkbox"/>	
	18. English as second language	<input type="checkbox"/>	
	19. Job placement/referral	<input type="checkbox"/>	
	20. Prenatal medical care	<input type="checkbox"/>	
	21. Postpartum medical care	<input type="checkbox"/>	
	22. Urine drug screening	<input type="checkbox"/>	
	23. Treatment for medical problems	<input type="checkbox"/>	
	24. Treatment for emotional problems	<input type="checkbox"/>	

	not provided 0 = provided	provided by your agency 1 = provided	provided by different agency 2 = provided
25. Medication for withdrawal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Medication for medical problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Medication for emotional problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. TB testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. TB treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. STD testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. STD treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**DETOX CLIENTS STOP HERE**

**EVALUATION OF CLIENTS GOAL ACHIEVEMENT**  
(Mark X in appropriate boxes)

	Not applicable	Achieved	Partial achievement	Not achieved
32. Overall program goals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Alcohol use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Educational/Vocational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. Social functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. Emotional functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. Family situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. Illegal behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

40. Currently receiving services from state agencies?  
(Mark X for all that apply)

DMR	<input type="checkbox"/>	
DMH	<input type="checkbox"/>	OTH <input type="checkbox"/>
OCF	<input type="checkbox"/>	MCDHH <input type="checkbox"/>
MPB	<input type="checkbox"/>	MCB <input type="checkbox"/>
DOC	<input type="checkbox"/>	MRC <input type="checkbox"/>
DYS	<input type="checkbox"/>	OCCS <input type="checkbox"/>
DSS	<input type="checkbox"/>	DTA <input type="checkbox"/>
None	<input type="checkbox"/>	DPH <input type="checkbox"/>

**\*\* See code numbers on back of pink copy**

50. Interviewer Initials

## OUTPATIENT CLIENTS

*(Includes methadone and DAE clients)*

41. Drinking behavior at discharge

0 = no alcohol use    3 = increased use

1 = decreased use    9 = unknown

2 = no change

42. Drug use other than alcohol at discharge

0 = no drug use    3 = increased use

1 = decreased use    9 = unknown

2 = no change

43. Alcohol use freq. since admission\*

44. Drug (Other than alcohol) used most since admission\* (none = X)

45. Drug (Other than alcohol) use frequency since admission\* (no use = 0) (if more than one - (drug used most))

## DRUNKEN DRIVER CLIENTS

(Discharge from DAE and 14-day DUIL only)

46. Date first group (mmddyy)

47. BAC this arrest Enter two digits only. No decimal point  
88 = does not know, 99 = refused test

48. Lifetime arrests for DUI

49. DUI convictions past 6 years. Include current conviction. Do not include subsequent convictions

50. Interviewer Initials

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH  
DISCHARGE INTERVIEW RESPONSE CODES

SUBSTANCE ABUSE SERVICES

5. Reason for discharge

- 0 = Dropout
- 1 = Completed
- 2 = Noncompliance/administrative
- 3 = Relapse
- 4 = Assessment
- 5 = Inappropriate
- 6 = Incarcerated
- 7 = Died
- 8 = Hospitalized
- 9 = Moved

8. Where was the client referred

- 00 = Referral not needed
- 98 = Referral not wanted

Individual

- 01 = Non medical professionals

Substance Abuse Treatment

- 02 = Room 5/Central Intake
- 03 = ATS - Level A
- 04 = Transitional Support Services
- 05 = ATS - Level B
- 06 = Residential
- 07 = Outpatient
- 08 = Methadone services
- 09 = Drunk driving program
- 10 = Acupuncture
- 11 = Gambling
- 13 = Youth program
- 14 = Sober House
- 19 = Other

Other Health Care Provider

- 20 = Primary care provider, hospital, emergency room, mental health provider

Educational

- 30 = School personnel, school systems

Employer/EAP

- 40 = Supervisor/employee counselor

Other Community Referral

- 50 = Shelter
- 51 = Community and religious organizations, social service agencies other than state agencies

Criminal Justice Referral

- 60 = Court - Section 35
- 61 = Court - DUI
- 62 = Court - Drugs
- 63 = Court - Other
- 64 = Police
- 65 = County House of Correction/jail
- 66 = Office of Community Corrections
- 67 = Dept. of Corrections
- 68 = Dept. of Probation
- 69 = Massachusetts Parole Board
- 70 = Dept. of Youth Services

Other State Agencies

- 71 = Dept. of Social Services
- 72 = Dept. of Mental Health
- 73 = Dept. of Mental Retardation
- 74 = Dept. of Public Health
- 75 = Dept. of Transitional Assistance
- 76 = Office of Child Care Services
- 77 = Mass. Rehab. Commission
- 78 = Mass. Commission for Blind
- 79 = Mass. Comm. for Deaf & Hard of Hearing
- 80 = Other

9. Employment Status at Discharge

- 0 = Not in labor force
- 1 = Looking for work
- 2 = Working part-time
- 3 = Working full-time
- 9 = Unknown

40. Receiving Services from State Agencies?

- DSS = Dept. of Social Services
- DYS = Dept. of Youth Services
- DOC = Dept. of Corrections
- MPB = Mass. Parole Board
- OCP = Office of the Commissioner of Probation
- DMH = Dept. of Mental Health
- DMR = Dept. of Mental Retardation
- DPH = Dept. of Public Health
- DTA = Dept. of Transitional Assistance
- OCCS = Office of Child Care Services
- MRC = Mass. Rehab. Commission
- MCB = Mass. Comm. for Blind
- MCDHH = Mass. Comm. Deaf & Hard of Hearing
- OTH = Other State Agency

43. Alcohol Use Frequency Since Admission

- 0 = No use
- 1 = Less than once a month
- 2 = 1-3 Times per month
- 3 = 1-2 Times a week
- 4 = 3-6 Times a week
- 5 = Daily
- 9 = Unknown

44. Drug Used Most Since Admission

(Other than alcohol)

- X. = None
- B. = Cocaine
- C. = Crack
- D. = Marijuana/Hashish
- E. = Heroin
- F. = Non Rx. Methadone
- G. = Oth. Opiates/Synthetics
- H. = PCP
- I. = Oth. Hallucinogens
- J. = Methamphetamine
- K. = Oth. Amphetamines
- L. = Oth. Stimulants
- M. = Benzodiazepines
- N. = Oth. Tranquilizers
- O. = Barbiturates
- P. = Oth. Sedatives/Hypnotics
- Q. = Inhalants
- R. = Over-the-counter
- S. = Other
- U. = Unknown

45. Drug Use Frequency Since Admission

- 0 = No use
- 1 = Less than once a month
- 2 = 1-3 Times per month
- 3 = 1-2 Times a week
- 4 = 3-6 Times a week
- 5 = Daily
- 9 = Unknown

SITE CODE ☐ ☐ ☐ ☐ ☐ ☐

## DRUNKEN DRIVER CLIENTS

34. Date of arrest (mmddyy)

### 35. Referring Court

(Court codes on back of yellow page)

## PATTERN OF SUBSTANCE USE

Complete 36 for all substances. If  $36 = 0$  leave 37-39 blank.

Use codes on back of pink copy for 37-39

<input type="checkbox"/>	None
<input checked="" type="checkbox"/>	MBHP
<input type="checkbox"/>	HMO
<input type="checkbox"/>	Private
<input type="checkbox"/>	Medicaid
<input type="checkbox"/>	Medicare
<input type="checkbox"/>	Other

COLLATERAL CLIENTS STOP HERE

## HANDICAPS/DISABILITIES

25. Use of mobility aid (Mark X for all that apply)

☒ None ☐ Crutches ☐ Walker ☐ Manual Wheelchair ☐ Electric Wheelchair

(See codes on yellow page for 26-30)

## 26. Vision impairment

## 27. Hearing impairment

28. Self Care/ADL Skills impairment

## 29. Mental retardation

## TREATMENT/SERVICE HISTORY

30. Prior mental health treatment (*See codes*)

31. Number of prior admissions to each substance abuse modality (none = 0, 9 or more = 9)

Detox	Residential	Outpatient	Methadone	Drunk Driver	Other
1	1	1	1	1	1
2	2	2	2	2	2
3	3	3	3	3	3
4	4	4	4	4	4
5	5	5	5	5	5
6	6	6	6	6	6
7	7	7	7	7	7
8	8	8	8	8	8
9	9	9	9	9	9
10	10	10	10	10	10
11	11	11	11	11	11
12	12	12	12	12	12
13	13	13	13	13	13
14	14	14	14	14	14
15	15	15	15	15	15
16	16	16	16	16	16
17	17	17	17	17	17
18	18	18	18	18	18
19	19	19	19	19	19
20	20	20	20	20	20
21	21	21	21	21	21
22	22	22	22	22	22
23	23	23	23	23	23
24	24	24	24	24	24
25	25	25	25	25	25
26	26	26	26	26	26
27	27	27	27	27	27
28	28	28	28	28	28
29	29	29	29	29	29
30	30	30	30	30	30
31	31	31	31	31	31
32	32	32	32	32	32
33	33	33	33	33	33
34	34	34	34	34	34
35	35	35	35	35	35
36	36	36	36	36	36
37	37	37	37	37	37
38	38	38	38	38	38
39	39	39	39	39	39
40	40	40	40	40	40
41	41	41	41	41	41
42	42	42	42	42	42
43	43	43	43	43	43
44	44	44	44	44	44
45	45	45	45	45	45
46	46	46	46	46	46
47	47	47	47	47	47
48	48	48	48	48	48
49	49	49	49	49	49
50	50	50	50	50	50
51	51	51	51	51	51
52	52	52	52	52	52
53	53	53	53	53	53
54	54	54	54	54	54
55	55	55	55	55	55
56	56	56	56	56	56
57	57	57	57	57	57
58	58	58	58	58	58
59	59	59	59	59	59
60	60	60	60	60	60
61	61	61	61	61	61
62	62	62	62	62	62
63	63	63	63	63	63
64	64	64	64	64	64
65	65	65	65	65	65
66	66	66	66	66	66
67	67	67	67	67	67
68	68	68	68	68	68
69	69	69	69	69	69
70	70	70	70	70	70
71	71	71	71	71	71
72	72	72	72	72	72
73	73	73	73	73	73
74	74	74	74	74	74
75</					

					
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32. Beginning of treatment episode? (Y = yes, N = no)

33. Currently receiving services from state agencies?\*

(Mark X for all that apply)

<input checked="" type="checkbox"/>	None	<input type="checkbox"/>	DSS	<input type="checkbox"/>	DYS	<input type="checkbox"/>	DDC	<input type="checkbox"/>	MPB	<input type="checkbox"/>	OCP	<input type="checkbox"/>	DMH	<input type="checkbox"/>	DMR
-------------------------------------	------	--------------------------	-----	--------------------------	-----	--------------------------	-----	--------------------------	-----	--------------------------	-----	--------------------------	-----	--------------------------	-----

21. Where does client usually live \*

\*See code back of pink copy

Primary Substance	<input checked="" type="checkbox"/>	Secondary Substance	<input type="checkbox"/>	Tertiary Substance	<input type="checkbox"/>
41. Last needle use (Use code for 37/never=0)	<input type="checkbox"/>				<input type="checkbox"/>
42. Interviewer Initials	<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>

## MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

## SUBSTANCE ABUSE SERVICES

## ADMISSION INTERVIEW RESPONSE CODES

## 6. Source of referral

- Individual**  
 01 = Self, family, friends, non medical professionals
- Substance Abuse Treatment**  
 02 = Room 5/Central Intake  
 03 = ATS - Level A  
 04 = Transitional Support Services  
 05 = ATS - Level B  
 06 = Residential  
 07 = Outpatient  
 08 = Methadone services  
 09 = Drunk driving program  
 10 = Acupuncture  
 11 = Gambling  
 13 = Youth program  
 14 = Sober House  
 15 = Information and Referral  
 17 = Second Offender Aftercare  
 19 = Other
- Other Health Care Provider**  
 20 = Primary care provider, hospital, emergency room, mental health provider.
- Educational**  
 30 = School personnel, school systems
- Employer/EAP**  
 40 = Supervisor/employee counselor
- Other Community Referral**  
 50 = Shelter  
 51 = Community and religious organizations, social service agencies other than state agencies
- Criminal Justice Referral**  
 60 = Court - Section 35  
 61 = Court - DUI  
 62 = Court - Drugs  
 63 = Court - Other  
 64 = Police  
 65 = County House of Correction/Jail  
 66 = Office of Community Corrections  
 67 = Dept. of Corrections  
 68 = Dept. of Probation  
 69 = Massachusetts Parole Board  
 70 = Dept of Youth Services
- Other State Agencies**  
 71 = Dept. of Social Services  
 72 = Dept. of Mental Health  
 73 = Dept. of Mental Retardation  
 74 = Dept. of Public Health  
 75 = Dept. of Transitional Assistance  
 76 = Office of Child Care Services  
 77 = Mass. Rehab. Commission  
 78 = Mass. Commission for Blind  
 79 = Mass. Comm. for Deaf & Hard of Hearing  
 80 = Other

## 12. Race

- 1 = Alaskan Native  
 2 = American Indian  
 3 = Asian/Pacific Islander  
 4 = Black  
 5 = White  
 6 = Other  
 9 = Unknown

## 13. Ethnicity/Ancstry

- Hispanic  
 01 = Puerto Rican  
 02 = Dominican  
 03 = Mexican  
 04 = Cuban  
 05 = Central American  
 06 = Other Hispanic  
 Portuguese  
 07 = Brazilian  
 08 = Cape Verdean  
 09 = Other Portuguese  
 Asian  
 10 = Chinese  
 11 = Cambodian  
 12 = Vietnamese  
 13 = Laotian  
 14 = Other Asian  
 Other  
 15 = Haitian  
 16 = West Indian  
 17 = Pakistani/Asian Ind.  
 18 = European  
 19 = African  
 20 = North American  
 21 = Other  
 98 = Unknown

## 14. Language Most Used

- 1 = English  
 2 = Spanish  
 3 = Portuguese  
 4 = French  
 5 = Asian Language  
 6 = Other

## 15. Marital Status

- 0 = Never Married  
 1 = Married  
 2 = Separated  
 3 = Divorced  
 4 = Widowed

## 18. Employment Status

- 0 = Not in labor force  
 1 = Looking for work  
 2 = Working part-time  
 3 = Working full-time

## 20. Clients Annual Income

- 0 = None  
 1 = Less than \$1,000  
 2 = \$1,000 to \$4,999  
 3 = \$5,000 to \$7,499  
 4 = \$7,500 to \$9,999  
 5 = \$10,000 to \$14,999  
 6 = \$15,000 to \$19,999  
 7 = \$20,000 to \$29,999  
 8 = \$30,000 or more

## 21. Where Does Client Usually Live

- 1 = House or apartment  
 2 = Room/boardng house  
 3 = Institution  
 4 = Group home  
 5 = Shelter/mission  
 6 = On the streets

## 26.-30. Handicaps/Treatment History (see yellow page)

## 33. Receiving Services From State Agencies

- DSS = Dept. of Social Services  
 DYS = Dept. of Youth Services  
 DOC = Dept. of Corrections  
 MPB = Massachusetts Parole Board  
 OCP = Office of the Commissioner of Probation  
 DMH = Dept. of Mental Health  
 DMR = Dept. of Mental Retardation  
 DPH = Dept. of Public Health  
 DTA = Dept. of Transitional Assistance  
 OCCS = Office of Child Care Services  
 MRC = Mass. Rehab. Commission  
 MCB = Mass. Commission for Blind  
 MCDHH = Mass. Comm. Deaf & Hard of Hearing  
 OTH = Other State Agency

## 36. Age of First Use

- 0 = Never used  
 Alcohol Use = age of first intoxication  
 Drug Use = age of first use

## 37. Last Use

- 1 = 12 or more months ago  
 2 = 3-11 months ago  
 3 = 1-2 months ago  
 4 = 1-3 weeks ago  
 5 = Used in last week

## 38. Freq. of Last Regular Use

- 1 = Less than once a month  
 2 = 1-3 Times per month  
 3 = 1-2 Times a week  
 4 = 3-6 Times a week  
 5 = Daily

## 39. Usual Route of Administration

- 1 = Oral  
 2 = Smoking  
 3 = Inhalation  
 4 = Injection  
 5 = Other



CAB Health &amp; Recovery Services

Inpatient/Boston/Danvers

Outpatient/Boston/Danvers

## Detoxification Discharge Summary

**Client Name:** Allen, Joseph **Date of Birth:** 5-30-78 **Client File #:** \_\_\_\_\_  
**Date of Admission:** 3-25-04 **Date of Discharge:** 3-27-04 **Program:** Detox

**Billing/Service Codes for SA IP (15)**Detox (100)

Section 35 (106)

Pregnant (107)

Shelter (115)

**Presenting problems and reasons for admission:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> alcohol dependence | <input checked="" type="checkbox"/> opiate dependence | <input type="checkbox"/> benzodiazepine dependence |
| <input type="checkbox"/> cocaine dependence | <input type="checkbox"/> barbiturate dependence       |  |

**TB Status**

Has the client been screened for TB?

Yes or No

If yes, was the screen?

Positive or Negative

If positive, is there a copy of current x-rays available?

Yes or No

**Summary and Progress/Course of Treatment:**

- ☐ fully complied with and progressed in treatment ☒ partially complied with and progressed in treatment  
☐ poor compliance with and progress in treatment  
 Gains achieved:

**Reason for Termination:**

- ☐ AMA ☒ APA ☐ Administrative Discharge and reasons: \_\_\_\_\_  
☐ Completed treatment

**At Time of Discharge:****Status of drug/alcohol use:**

- ☐ drug-free ☒ some use evident ☐ not completely detoxified

**Medication Information (if applicable):**

--

**Discharge Summary (Continued)**

<b>Strengths:</b> <i>none</i>
<b>Needs:</b> <i>job, good life for self &amp; family</i>
<b>Abilities:</b> <i>cutting hair, carpentry</i>
<b>Preferences:</b> <i>short hair</i>

**Diagnoses at discharge:**Axis I *304.00 organic del.*Axis II *799.9 delusional*Axis III *it represents jump in delusional*Axis IV *s/o judgment, unemployed*

Axis V

Highest past: *5/*Current: *4/***Aftercare plan, referrals made, and follow-up plans:***Dr. APD to our plan*

Clinician's Name:

*Dr. CHARLTON-WOOD*

Signature:

*Dr. Charlton-Wood, MD*

Date:

*3-28-04*

Has temp MH Card  
He will bring it  
to Him

3/25/04  
4pm



**CAB Health & Recovery Services**

*Treatment makes a difference. Recovery makes a life.*

Department of Health & Human Services

## Admissions Pre-Screening Form

Form Completed By: Rachel Moffat/CAB

<b>Admit Date/Time:</b>	<b>MIS:</b> 3398346	<b>DRS:</b>
<b>Client's Name: (Last, First, Middle)</b> Allen, Joseph		<b>Allergies:</b> NKA
<b>DOB:</b> 05/30/78	<b>Sex:</b> Male	<b>SSN:</b> 029-58-2491

<b>Home Phone:</b> 9784796192	<b>Okay to Call:</b> Yes	<b>Work Phone:</b>	<b>Okay to Call:</b>
----------------------------------	-----------------------------	--------------------	----------------------

**Address: (Street, City, State, Zip)**  
8 Reservoir Rd.

Gloucester, ma 01930

<b>Type of Event:</b> Re-Admission	<b>Type of Service:</b> Detoxification	<b>Counselor:</b>
<b>Emergency Contact:</b> alicia parisi (s/o)		<b>Phone:</b> 9784796192

<b>ETHNIC BACKGROUND</b>	<b>MARITAL STATUS</b>
Caucasian	Single
<b>LANGUAGE</b>	<b>DISABILITY</b>
English	

<b>SOCIO-ECONOMIC/VOCATIONAL BACKGROUND</b>		
<b>Education</b> Less than High School	<b>Occupation</b> Unemployed	<b>Income</b>

<b>CLIENT REFERRAL SOURCE</b> Self
---------------------------------------

<b>PAY SOURCE INFORMATION</b>	<b>POS Verification</b> Not Found
MBHP - basic	

<b>Cardholder Name:</b>	<b>Policy #:</b>	<b>SSN:</b>
<b>Employer:</b>	<b>Policy #:</b>	<b>Group #:</b>
<b>Insurance Co.:</b> MBHP - basic	<b>Policy #:</b>	<b>Group #:</b>
<b>Address:</b>		<b>Phone:</b>
<b>Verification Date:</b>	<b>Verified by:</b>	<b># of Days Approved:</b>
<b>Authorization #:</b>		
<b>Plan:</b>	<b>Deductible:</b>	<b>Co-Pay:</b>

Balance of Lifetime Coverage for Inpatient Care:

Indicate if client has had any history of the following conditions by placing an X in the respective box. Please comment if neces:

NEUROLOGICAL	CARDIOVASCULAR	PULMONARY	GASTROINTESTINAL	GENITOURINA
<input type="checkbox"/> Seizures	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Stones
<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Asthma	<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Recurrent UT
<input type="checkbox"/> Head Injury	<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hepatitis Type	<input type="checkbox"/> PID
<input type="checkbox"/> Unconsciousness	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Chronic Bronchitis	<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Venereal Disc
<input type="checkbox"/> Other	<input type="checkbox"/> Chest Pain*	<input type="checkbox"/> Shortness of Breath*	<input type="checkbox"/> Other	<input type="checkbox"/> Diabetes
		<input type="checkbox"/> Other		<input type="checkbox"/> Cancer

**Comments:** denies

<b>PSYCHIATRIC</b>	<b>MEDICAL</b>	<b>OB/GYN</b>
--------------------	----------------	---------------



If patient is on prescription medication, medication must be brought in original prescription bottle				
<b>CURRENTLY TAKING</b>  Rx Name: Dose: Frequency:  Rx Name: Dose: Frequency:	<b>CURRENTLY TAKING</b>  Rx Name: Dose: Frequency:  Rx Name: Dose: Frequency:	The following medications require prior to acceptance for admission: <input type="checkbox"/> Coumadin (PT INR) <input type="checkbox"/> Clozapine (CBC WBC) <input type="checkbox"/> Digoxin Levels <input type="checkbox"/> Lithium Levels <input type="checkbox"/> Depakote Levels (Only taken) <input type="checkbox"/> Dilantin Levels <input type="checkbox"/> Blood Glucose Levels <b>Blood glucose levels are required for insulin dependent diabetes</b>		
Prescribing Physician: Emergency Contact: see above		Phone:		
<b>DRUG HISTORY</b>				
<b>Alcohol</b> Type: Quantity: Frequency: Last Use: Length of Use:	<input type="checkbox"/> Cocaine <input type="checkbox"/> Heroin <input checked="" type="checkbox"/> Oxycontin <input type="checkbox"/> Benzodiazepine <input type="checkbox"/> Cannabis	Quantity: 160MG Frequency: qd Routes: sniff Last Used: 3/24/04 Length of Use: 1 1/2 years		
<b>TREATMENT HISTORY</b>				
Longest Sobriety/Clean Time: 1 week When: How: Last Detoxification				
Have You Considered a Methadone Clinic? <input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/> Max Dose				
Facility Name: Date: Program Name: Date:				
<b>Consciousness</b> <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Drowsy <input type="checkbox"/> Stuporous <input type="checkbox"/> Unconscious <input type="checkbox"/> Unresponsive	<b>Gait</b> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Ataxic <input type="checkbox"/> Unable to Test  <b>PPD</b> Current PPD <input type="radio"/> Yes <input checked="" type="radio"/> No Date: 3/25/04	<b>Skin</b> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Dry  <b>Mouth</b> <input type="checkbox"/> Moist <input type="checkbox"/> Dry	<b>Trauma</b> No  <b>Eyes</b> <input checked="" type="checkbox"/> Pupils Equally Reactive <input type="checkbox"/> Pupils Nonreactive <input type="checkbox"/> EOM's Full <input type="checkbox"/> Limited <input type="checkbox"/> Nystagmus <input type="checkbox"/> Yes above six beats Pupil Size: mm 2.5  <b>Neck Range of Motion</b>	<b>Pregnancy Test</b> Date:  <b>Initial Clinical Diagnosis</b> Axis I Diagnosis 304.00 Opiate
<b>CHEST Breath Sounds</b> <input checked="" type="checkbox"/> Equal Bilat. <input type="checkbox"/> Crackles <input type="checkbox"/> Wheezes <input type="checkbox"/> Rhonchi <input checked="" type="checkbox"/> Clear	<b>HEART</b> <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular  <b>ABDOMEN</b> <input type="checkbox"/> Tender <input type="checkbox"/> Scars <input checked="" type="checkbox"/> Normal Liver	<b>EXTREMITIES</b> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Edema  <b>Needle Marks</b> <span style="float: right;"><b>Severity</b></span> <input type="checkbox"/> Ant. Cubital <input type="checkbox"/> Neck <input type="checkbox"/> Wrists/Forearms <input type="checkbox"/> Legs <input type="checkbox"/> Abscesses  Temperature: Pulse: 97 135/102 Blood Pressure: R: 16		
<b>PRIMARY CARE PHYSICIAN:</b> none				
Nurse Signature: <i>[Signature]</i>	Date: 3/25/04	Doctor's Signature: <i>[Signature]</i>	Date: 5/4/04	



☒ Hospitalization\*  
Month/Year: bayridge 2002

Reason:  
observation

☐ Suicidality

Month/Year: denies

☐ Intoxicated at the time?

☐ Hospitalization\*  
Month/Year:

Reason:  
denies

☐ Operations (If different from above)

Reason:

☐ Pregnant\*  
Trimester/Month:

☐ Receiving physicians care  
Consulting Physician:

☐ Referral for Care

**Do you have any court cases?** No When? Why?

**Do you have any warrants?** No





# Detoxification Client Assessment Form

(For clients re-admitted within the past year)  
(Attach update form to old psychosocial assessment)

Name of Client: <i>Allen, Joseph M.</i>	D.O.B.: <i>5/30/78</i>
DRS #:	Age: <i>25</i>
Clinician: <i>Gary DeVine</i>	Admission Date: <i>3/26/09</i>
Payor Source: <i>Temp. Mass Health</i>	

## Chief Complaint/Presenting Problem:

Why is client here? Why does client say they are here for treatment? What does client want? Referral source can use quotes:

*Self-referred for opiate detox*

*120 mg of Oxy or 2 bags of PD q.d.*

## Current Precipitants:

(What has occurred recently to bring client into treatment? Why now? What has been going on for last 1-2 months that can relate to this current illness episode? Recent stressors precipitants? Was abstinence recently broken?)

*S/O of GYIS is pregnant.*

## Substance Abuse History and Treatment:

*S/A Hx → etohca 15 yrs. & cannabis shortly after. 1996/97 he was sent to jail. At that time he recognized etoh was a problem. Began using opiates heavily when his fa died 2 yrs ago. 2<sup>nd</sup> detox. Has had some OPC.*

## Psychiatric History and Treatment:

*denies*

## Current Medications:

*denies*

## Suicide Attempts:

*denies*

## Current Treatment Providers and Telephone Numbers:

*denies*



## Detoxification Client Assessment Form (Continued)

Client Name: Allen

Client ID: \_\_\_\_\_

## Social/Developmental History:

Fa had 17 children. Grew up w 1 sis and m3 and 2 half sibs. S/A in F/O. At 12/13 y.o. until 17 y.o. he bounced back & forth between parents. He grew up wanting a father.   
☒ Verb/A ☒ Phys/A

## Current Living Situation and Family System:

Lvg w S/O of 6yrs in downstairs apt. of her parents house.

## Sexual Orientation/Preference:

Hetero.

## Educational History:

Dropped out in 10<sup>th</sup> grade. Has a GED.

## Vocational History:

Construction. Lost his job when he refused to help his employer cop. Unemployed since Oct.

## Financial Status:

"No cash" Lost a \$150,000 lawsuit. Has considerable cc debt.

## Legal History:

☒ Issues

## What are your current preferences for treatment?

ICP

## Do you presently have a sober support system? If yes, who and what does this consist of?

☒ sponsor

## Leisure Activities and Interests:

Cutting hair. Playing Flag football

## Any religion or spiritual involvement? What makes life meaningful for you?

☒ Religion / "Life itself. Happy to be alive."

## Ethnic origin (culture):

White

## Medical History:

## (Current Medications)

☒ Issues. "Has a lump in stomach."



## Detoxification Client Assessment Form (Continued)

Client Name: Allen

Client ID: \_\_\_\_\_

## Mental Status:

Appearance: Appropriate ☒ Inappropriate \_\_\_\_\_ Clean \_\_\_\_\_ Unkempt \_\_\_\_\_ Other \_\_\_\_\_Eye Contact: Good ☒ Avoids Eye Contact \_\_\_\_\_ Stares into Space \_\_\_\_\_ Glances About \_\_\_\_\_Behavior: Cooperative ☒ Hostile \_\_\_\_\_ Anxious \_\_\_\_\_ Fearful \_\_\_\_\_ Lethargic \_\_\_\_\_ Silly \_\_\_\_\_ Withdrawn \_\_\_\_\_  
Restless \_\_\_\_\_ Able to Focus \_\_\_\_\_ Easily Distracted \_\_\_\_\_ Other \_\_\_\_\_Orientation: To person ☒ Place ☒ Time ☒Memory: Unremarkable ☒ Short term impaired \_\_\_\_\_ Long-term impaired \_\_\_\_\_ Fluctuating \_\_\_\_\_

Affect: Full range \_\_\_\_\_ Flat \_\_\_\_\_ Labile \_\_\_\_\_ Angry \_\_\_\_\_ Sad \_\_\_\_\_ Euphoric \_\_\_\_\_ Cheerful \_\_\_\_\_ Anxious \_\_\_\_\_

Suicidality: No reported ideation ☒ Ideation w/o plan \_\_\_\_\_ Ideation with plan \_\_\_\_\_Homicidality: No reported ideation ☒ Ideation w/o plan \_\_\_\_\_ Ideation with plan \_\_\_\_\_

Delusions \_\_\_\_\_ Hallucinations \_\_\_\_\_ If checked please record details: \_\_\_\_\_

Note: \_\_\_\_\_  
\_\_\_\_\_Speech: Clear ☒ Pressured \_\_\_\_\_ Disorganized \_\_\_\_\_ Incoherent \_\_\_\_\_ Slurred \_\_\_\_\_ Slowed \_\_\_\_\_Thought Content: Unremarkable ☒ Self-blaming \_\_\_\_\_ Bizarre \_\_\_\_\_ Grandiose \_\_\_\_\_  
Paranoid \_\_\_\_\_ Preoccupied \_\_\_\_\_ (please specify) \_\_\_\_\_Cognition: Unremarkable \_\_\_\_\_ Concrete ☒ Distractible \_\_\_\_\_ Confused \_\_\_\_\_ Capacity for Insight \_\_\_\_\_Intelligence: Above average \_\_\_\_\_ Average \_\_\_\_\_ Below Average ☒ Unknown \_\_\_\_\_Comments: \_\_\_\_\_  
\_\_\_\_\_

What are client's strengths?

"Right now, none."

What are client's current needs?

A job. A good life for self and family.

What are client's abilities/aptitudes?

Cutting hair. Carpentry.

What are client's current preferences?

Short Tx



## Detoxification Client Assessment Form (Continued)

Client Name: Allen

Client I.D.:

## Diagnostic Formulation:

(How does the client's past play a role in current difficulties? How do alcohol/drugs help this client? How do you understand why this client behaves the way he or she does? What are client's current modes of operating in the world in addition to substance use which cause this client difficulties? Attempt to link current stressors and past history to current difficulties)

This CT is a 25 y.o. SWM who self-referred for opiate detox, his 1st effort at sobriety. The CT does not appear to have any other issues, S/A in F/O. He is impulsive and his self-esteem is low, stemming from a lack of bonding & his father's stability in his upbringing. He reports to be motivated by the announcement of his g.f.'s pregnancy. He intends to do the Discovery Program.

## DSM IV DIAGNOSIS:

Axis I: 304.00 OxyAxis II: 789.90Axis III: Reports to have a lump in his abdomen.Axis IV: S/O is pregnant and the CT is unemployed.Axis V: Current 46 Highest Past Year 51 Lowest Past Year 44

## Treatment Recommendations:

(Recommend level of care, other services or supports needed, aftercare plans)

The CT plans on entering an IOP program.

## Acceptance of Recommendations and Treatment Preference

Clinician Name (Printed)

Date

Clinician Signature



# Comprehensive Treatment Plan (Inpatient)

Problem	Goal	Objectives	Interventions
Drug addiction	"To get clean & sober."	- Safely detox - "To listen to others"	- Med protocol - Meetings

  

Client Name:	Joseph M. Allen	Record #	
Date:	3/26/04	Clinician:	Gary DeVine

Revision Date: 04/03, CAB Health &amp; Recovery Services

STEVEN M. CHISHOLM  
Clinical Supervisor

404 Comprehensive Treatment Plan  
Inpatient/Boston/Danvers





CAB Health & Recovery Services  
 100 State Street, Suite 200  
 Boston, MA 02109

## Detoxification Progress Notes

<b>Client Name:</b> <u>Joseph Allen</u>	<b>DRS #:</b>
<b>Date:</b> <u>3/26/04</u>	
Progress or lack of progress on Treatment Goal #1 and specific related treatment objectives:	
<u>Psoc &amp; Tx plan are completed. The CT has attended groups today. The CT decided to skip a dose to leave early.</u>	
Progress or lack of progress on Treatment Goal #2 and specific related treatment objectives:	
Other (strengths, needs, psychosocial stressors, other newly identified concerns, etc.)	
<b>Signature:</b> <u>[Signature]</u>	
<b>Date:</b> <u>3-27-04</u>	
Progress or lack of progress on Treatment Goal #1 and specific related treatment objectives:	
<u>OC ADA to our plan</u>	
Progress or lack of progress on Treatment Goal #2 and specific related treatment objectives:	
Other (strengths, needs, psychosocial stressors, other newly identified concerns, etc.)	
<b>Signature:</b> <u>[Signature]</u>	
<b>Date:</b> <u> </u>	
Progress or lack of progress on Treatment Goal #1 and specific related treatment objectives:	
Progress or lack of progress on Treatment Goal #2 and specific related treatment objectives:	
Other (strengths, needs, psychosocial stressors, other newly identified concerns, etc.)	
<b>Signature:</b>	



CAB Health &amp; Recovery Services

# Detoxification Progress Notes

<b>Client Name:</b>	<b>DRS #:</b>
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<b>Date:</b>	
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Progress or lack of progress on Treatment Goal #1 and specific related treatment objectives:

Progress or lack of progress on Treatment Goal #2 and specific related treatment objectives:

Other (strengths, needs, psychosocial stressors, other newly identified concerns, etc.)

**Signature:**

<b>Date:</b>	
--------------	--

Progress or lack of progress on Treatment Goal #1 and specific related treatment objectives:

Progress or lack of progress on Treatment Goal #2 and specific related treatment objectives:

Other (strengths, needs, psychosocial stressors, other newly identified concerns, etc.)

**Signature:**

<b>Date:</b>	
--------------	--

Progress or lack of progress on Treatment Goal #1 and specific related treatment objectives:

Progress or lack of progress on Treatment Goal #2 and specific related treatment objectives:

Other (strengths, needs, psychosocial stressors, other newly identified concerns, etc.)

**Signature:**



**CAB**  
HEALTH RECOVERY  
SERVICES, INC.

## Admission Progress Notes Nursing Levels A,B,C

*Treatment makes a difference. Recovery makes a life*

Patient' Name:	Allan Joseph	Allergies:	NKA	Number:	3398346
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Date/Time	3/25/04 4:15 P -
T 98'	Secure CHB admission
P 72	for this 259.5. male who requests separate
F 16	deter. For 3725, 630 A, 11th day operation
BP 130/102	united. No med / psych issues. No sed of
	W/D. P/D LFA. Understands rules / reg.
	Especially noon. Report to nurse. No hold back
3-25-04	Ct begins m/a @ 8p. 5x93 Choked
4/15/04 (4'6" 11")	of compression. Medical i Methadone
	Sing as per protocol. Well out to March
	for opate u/D. ————
3/26/04 11:27	It. C/O consensus & was given bond of
	50 mg PO to good effect. It. was up x 2 for
	assessments for the M/P who reported he
	qualified both times & was given M/P dose 50
	mg each time. 13 g/o for supply & ration
	MMU Clinical MC
3/26/04	7-3 4 methadone assessment maint
	8/120 definite S/S withdrawal
	C/O chills/sweats pupils 6 mm
	In bed most AM, well continue
	to monitor L.I.
3-26-04	Continues on methadone protocol. Refused 4 <sup>th</sup>
B-11	assessment dose. Took 8 <sup>th</sup> dose. Up & about
	attending in top & meals. States he feels good except
	for gen. aches. Med @ 4 <sup>th</sup> , busipren per order
	& acetaminophen @ 8 <sup>th</sup> per order for 10 gen aches
	& mod. relief. ———— S. S. S. S. S.

**Admission Progress Notes, Nursing Levels A,B,C (Continued)**

Date/Time	
3/27/04 11-7	PT- Clo in somnia + was given Benadryl 50 mg PO to good effect. He was in bed most of the night. 1/5 go for safety & location. <del>MMI</del> <del>Alcohol</del> <del>Med</del>
3/27/04	7-3 Methadone BID dosing maint, up & about attending meal groups no C/O discomfort \ R. N.
3-27-04 3-630P	Up & about. Attended meal & vitals Sunday Left APA A.A.OX2 @ belonging & R.N. <del>Sunday</del>



CAB Health &amp; Recovery Services

# AUTHORIZATION (CONSENT) TO OBTAIN OR RELEASE INFORMATION AND RECORDS

Client Name: Allen, Joseph M.DOB: 5/30/78

DRS#: (CAB use only):

OBTAIN: I, Joseph Allen(Client or Parent/Guardian, if client is a minor) authorize CAB Health and Recovery Services, Inc., by fax or mail, to **obtain** information including medical and/or substance abuse and/or mental health records from:Discover @ Addison Gilbert 283-0296

(Name and telephone number of agency/school/physician)

Gloucester, MA

(Complete mailing address of agency/school/physician)

RELEASE: I, \_\_\_\_\_

(Client or Parent/Guardian, if client is a minor) authorize CAB Health & Recovery Services, Inc., via U.S. mail, to **release** information including medical and/or substance abuse and/or mental health records to:

(Name and telephone number of agency/school/physician)

(Complete mailing address of agency/school/physician)

Please indicate the **SPECIFIC** information to be disclosed: (Please complete each category)

<input checked="" type="radio"/> Y <input type="radio"/> N Dates of Services	<input type="radio"/> Y <input checked="" type="radio"/> N Progress Notes
<input type="radio"/> Y <input checked="" type="radio"/> N Intake Assessment Summary (Clinical Interview)	<input type="radio"/> Y <input checked="" type="radio"/> N Discharge Summary
<input type="radio"/> Y <input checked="" type="radio"/> N Treatment Plans	<input type="radio"/> Y <input checked="" type="radio"/> N Psychiatric Summaries/Medications
<input type="radio"/> Y <input checked="" type="radio"/> N Diagnoses	<input type="radio"/> Y <input checked="" type="radio"/> N Other

The purpose of this release of information is:

☐ Assist in Treatment Planning☐ Coordination of Treatment☐ Billing for Treatment Services Rendered☒ Evaluation☐ Other (specify): \_\_\_\_\_

## PROTECTED INFORMATION

Your signature below does not pertain to the categories listed below. Information in these protected categories will **not** be recorded or released from your record without your initials in the boxes below in addition to your signature.

## INITIAL ONLY THE CATEGORIES OR INFORMATION YOU WISH CAB HEALTH & RECOVERY SERVICES, INC. TO RELEASE:

☐ Hepatitis B  
Testing/Treatment☐ HIV/AIDS  
HIV Testing☐ Sexually Transmitted  
Diseases☐ Hepatitis C Testing  
Treatment

I understand that I have the right to inspect and copy the information to be disclosed. I understand that my records are protected under the federal regulations governing Confidentiality in Alcohol and Drug Abuse Patients, 42 CFR Part 2 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent automatically expires within 30 days after treatment, termination, or upon receipt of payment for treatment services rendered, whichever is longer, unless otherwise specified below:

(Specification of the date, event or condition upon which this consent expires, not to exceed one year.)

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_



CHAB Health and Recovery Services  
Aftercare Plan Tracking Form

I, Joseph Allen agree to the following aftercare plan:  
Client Name

Referral made to:

Discover  
Program Name

Contact Person

Time and date of appointment

Phone Number 978-283-0296

Fax Number

Please circle level of care:

1. Outpatient Treatment

2. TOP

3. Residential (Half Way House, TSS, Sober House)

4. Methadone

5. Other

To attend the following self-help meetings:

Monday \_\_\_\_\_  
Tuesday \_\_\_\_\_  
Wednesday \_\_\_\_\_  
Thursday \_\_\_\_\_  
Friday \_\_\_\_\_  
Saturday \_\_\_\_\_  
Sunday \_\_\_\_\_

I can ask for help from the following people, if I am at risk for using a substance or experiencing some other type of crisis:

Support Person Telephone Number

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If referral is made to non CHAB program, release form to obtain follow-up information completed and attached ☐ Yes ☐ No

Client Signature

Date

